Relational Truth-creation: Between Bare Literal Openness and Mutual Manipulation

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The intention of this article is to highlight some aspects that question a simplistic idea of truth as corresponding to the facts that is often implied in the imperative "Tell the truth!": the epistemological status of the biomedical information, the choice and development of relevant information, and the complicated process of adjusting two different ways of explanations with the actual state of affairs. Telling the truth is a delicate and complicated process, the more if it is embedded in other communicational tasks like therapy and diagnosis. It requires a successive development of mutual understanding, and it has educative and insofar also possibly manipulative aspects, that may on the first view contradict the guiding imperative. Thus, truth-telling is not translating a medical checklist to everyday language, but requires hermeneutic as well as constructive capacities from both, sender and receiver of the information.

Keywords: truth, correspondence theory of truth, constructivist theory of truth, patient-physician-relationship, doctor-patient-communication, professional ethics, informed consent, hermeneutics

> "Och oupphörligt blir man på nytt ställd inför Pilati gamla fråga: vad fan är sanning?"
> Hjalmar Söderberg, *Den allvarsamma leken*, 1912, 93

1. Introduction

One of the most common ethical demands on doctors is "to tell the truth". Heart-breaking stories are told from the 1950s and 60s, when "everything is all right" could either mean that everything was in fact all right, or that it was so bad that nothing could be done anymore. If a physician told a patient that he could go home, eat what he liked, do what he liked, had no reason to worry and no need for medical treatment or advice whatsoever, this could be

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scary information—possibly the worst one could get: e.g. untreatable cancer. Among doctors it was largely accepted that the physician was in command of the knowledge around disease, and it was her task to take decisions about necessary and useful treatments, and about the amount of information she gave to the patient. Especially very bad prognoses were often withheld from the patient. The reason for not telling a patient the truth about a fatal cancer diagnosis was not to harm the patient, additionally to his disease. The bad message that necessarily led to fear and psychological pain was seen as an avoidable harm, and the patient should be protected from it. In the words of modern principlism: The non-maleficence principle was given highest value in a situation where the doctor could not by medical means alleviate the patient's situation.

Since then, a shift of paradigm concerning truthful information of the patient from paternalism to autonomy has occurred. Already earlier, latest since the Nuremberg Codes from 1948, the necessity of full information and competent consent to experimentation on human beings has been confirmed. Today, a strategy of hiding painful truth from the patient is usually seen as obsolete and unacceptably paternalistic. It is not regarded as compatible with respect for the patient's autonomy to withhold information that is necessary for his decisions, even though some attention has been given to the fact that there is no duty to be autonomous in this understanding. There is not only a right to know, but also a right not to know against one's will, and the possibility to delegate the choice to others, e.g. to the medical expert.

In medical ethics, great attention has been attributed to the conditions that make autonomous decisions of the patient concerning his own health and his own treatment possible (Beauchamp and Childress 2009). A key element of a competent choice is the right kind of disclosure, i.e. the transfer of the necessary and relevant medical information from the physician to the patient in order to enable him to make an autonomous choice (Faden and Beauchamp 1986). The straightest idea of transfer of medical information from the doctor to the patient is implied in the informational physician-patient-relationship (Emanuel and Emanuel 1992).[1] According to this model, the doctor is seen exclusively as an expert in scientific medical knowledge and technical skills. She[2] has got no special responsibilities for the patient in addition to exerting this expertise. She has to transfer that part of her knowledge to the patient that is relevant for his decision-making, and after getting

[1] Emanual and Emanual distinguish four models of the physician-patient-relationship: informative, interpretative, deliberative and paternalistic; with a growing influence of the doctor on the decision-making.

[2] I am using 'she' for the doctor and 'he' for the patient, in order to simplify the use of pronouns.

the order of the patient, she should exert her technical skills at a satisfactory level of competence.

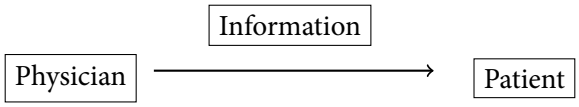

Fig. 1. *Informational model.*

It is an attractive model, as it makes paternalism impossible and guarantees that the values of the patient are decisive in the process of disease, diagnostics and therapy. In addition to this, it frees the doctor from the burdens of special moral obligations to the patient and his welfare. No special capacities to deal with existential states, with irrational fear, with dark psychological mechanisms, and with despair, are required. Competence in medical knowledge, technical skills, and openness and truthfulness to the patient are her only tasks. In the case of an end stage of cancer, there is no danger of misunderstanding, no ambivalence between different moral principles, and no danger of leaving the patient alone in a necessarily ignorant state guided by another person, who has artificially augmented the pre-existing asymmetry of essential information.

A disadvantage of this clear model is that it is far from reality. Identifying the relevant information is not only a matter of translating the medical language of the available scientific knowledge in everyday language. Starting from the point of "information", inspired from cybernetics[3] and information technology, the model excludes the delicate question of what is the truth that has to be transmitted: this has to be clear in advance. The question of truth is one of the oldest topics in philosophy; it has been widely discussed and is controversial. It surpasses the scope of this article to sketch the whole variety of positions, but some orientation might be useful. The classical definitions regard truth as a relational notion between the human mind and reality (Aquinas 1265–1274, I, q 21). Aristotle emphasized that the things come first, and the truthful description is primarily dependant on the

[3] "Cybernetics: Science of regulation and control in animals (including humans), organizations, and machines when they are viewed as self-governing whole entities consisting of parts and their organization. It was conceived by Norbert Wiener, who coined the term in 1948. Cybernetics views communication and control in all self-contained complex systems as analogous. It differs from the empirical sciences (physics, biology, etc.) in not being interested in material form but in organization, pattern, and communication in entities. Because of the increasing sophistication of computers and the efforts to make them behave in humanlike ways, cybernetics today is closely allied with artificial intelligence and robotics, and it draws heavily on ideas developed in information theory." http://www.merriam-webster.com/dictionary/cybernetics, accessed 21/11/2012.

things how they are (Aristotle 2009). The position that truth means correspondence with facts and reality is close to everyday understanding. On the other hand, with regard to fallibility of human perception and knowledge, it is doubtful how one ever could know for sure that one's convictions correspond to the "real facts". Actually, it is a hypothesis that there exist things that own a concrete essence independently of one's mind. Many theories have therefore focussed on truth criteria, i.e. the rules that must be followed for a statement to be defined as truthful. Logical truths are of this kind, but also coherence and consensus can serve this purpose. In postmodernism and radical constructivism (von Glasersfeld 1996) the existence of *one* truth is denied, and there is no objective standpoint from which competing constructions of reality can be judged.

In this article, there will be no comparison of theories and their arguments. The discussed question is a practical ethical one: How can and should a physician tell the truth to his patients, as required for Informed Consent and autonomous decision-making? The practical question implies, however, all the problems the theories of truth address. Hence, in the following, I intend to show that the doctor has to find, together with the patient, a position between a plain correspondence theory and a constructivist theory of truth.

The practical question may seem not very inventive. Much attention has been given by Beauchamp and Childress (2009), Faden and Beauchamp (1986) and Wear (1993) to how to weigh and balance principles and how to translate and adjust information to the patient's understanding. Physician-patient-communication is also subject of abundant empirical research. The focus of this article, however, is the theoretical question about the nature of that "truth" that is morally required in a disclosure. As I try to show is the above mentioned model of information misleading. It tends to imply a simpler distribution of necessary knowledge than there really is, and thus is tends to distribute the roles and the duties in an unrealistic way. A better and more complex understanding of the truth and the type and construction of the information it contains can result in a practical application of the moral demands that makes a difference, though the moral basis remains untouched.

I am using a combination of analytical and dialectical methods, therefore I give no stipulative definitions and derive their consequences, but I analyse and discuss different models with their strengths and weaknesses, developing step by step a synthesis of them as a result, not as a starting point of my reasoning. First I analyse shortcomings of a too simplistic everyday understanding of "telling the truth" and focus on the necessary interpretive and relational aspects of truth-telling (2.-4.). Then I address shortly the inapplicability of pure relational constructivism which is in clear opposition

to the very idea of modern medicine (5.). In the conclusion (6.), a synthesis of essential elements of both positions in form of relational truth creation in accordance with the available and relevant facts is supported.

2. Scientific evidence or what is "the truth" that has to been told?

Several levels of reality interfere with the elegant simplicity of the model in fig.1. The most basic one is implicit in medical epistemology, or more precisely, in general scientific epistemology. All available knowledge is not a direct possession of the facts themselves (Popper 1934). Science does not own reality and facts, but organizes experiences and tests these hypotheses in a systematic way. There is no endpoint included, and the everyday pretension "Science has proven that A is true", or "that A is the case" is an unscientific trivialisation. "Science at its current stage regards A as the best interpretation of all available evidence, and publishing these results invites to critical discussion", would be a more exact expression, in a scientific perspective.[4] Unfortunately, if one uses this description, the probable effect on a non-scientist will be the wrong impression that one doubts one's own pretensions, and that the state of affairs is a matter of mere belief or opinion. That is not the case. The knowledge is the *best available* knowledge, and only a better scientific model that explains as many or even more of all data would be a valid opponent. Doubting one's own theories is an inevitable aspect of all scientific knowledge, in clear contrast to all ideological certainty about how the world is. That is why science was able to discover and integrate so many facts and to give the best valid explanations for them today. There will be better explanations in future. Positivists believe (unscientifically) that all knowledge—a congruence of knowledge with all facts—is in principle available and once will be reached.[5]

Thus, an often neglected problem a doctor has who wants to tell a patient the scientific truth is to find out his stance on scientific knowledge. Does he naively take the available knowledge for the facts themselves? Does he, on the other hand, naively think some unproven belief systems are on the same level of evidence as the gathered available scientific knowledge? How will he understand the data she has to hand over to him? One expert opinion among

[4] A good introduction to philosophy of science is *What Is This Thing Called Science?* (1982).

[5] "Positivism: a theory that theology and metaphysics are earlier imperfect modes of knowledge and that positive knowledge is based on natural phenomena and their properties and relations as verified by the empirical sciences". "Logical positivism: a 20th century philosophical movement that holds characteristically that all meaningful statements are either analytic or conclusively verifiable or at least confirmable by observation and experiment and that metaphysical theories are therefore strictly meaningless". http://www.merriam-webster.com/dictionary/positivism, accessed 21/11/2012.

many others, and a matter of taste who is right? A godlike and unquestionable truth and she is the priest to reveal the fate? Both would not correspond to the real status of the truth she has to and can reveal. In addition, sitting at the doctor's reception, waiting anxiously for some decisive results that may be crucial for the patient's future, is hardly the right situation to get a concise course in epistemology. It is the wrong time for that, and I doubt one could find a single patient who would be open for that. If he is no epistemologist himself, however, there is a big chance that he will have the distorted idea of science that is usually spread in the media. So how does the doctor make sure that the patient receives her message in the right mode of certainty?

A second level of uncertainty adds to this general epistemological limitation: Nearly all available medical knowledge, apart from some banal exceptions,[6] is of statistical nature. In medicine, we move in a continuum of uncertainty. Evidence based medicine and biostatistics contribute to knowing more exactly how uncertain our knowledge is. Usually, a medication or a therapy help, say 60% of the patients (under controlled trial conditions) compared to 40% in the placebo group, while 20% develop headaches and sickness, (compared to 10% in the control group), and less than 1 in ten thousand will die of a specific life-threatening adverse effect. All this the doctor knows with a certain probability of error according to the design of the respective studies, plus an unknown probability of conflicts of interest that may have influenced the interpretations of the results. This is concrete and valuable knowledge as a basis of concrete practical decisions to be made. It requires training and experience to be able to take the necessary decisions on this basis. It is impossible to know for sure in advance if the special patient in front of her will profit, suffer or even die as a consequence of the decision that has to been made. This applies not to a few or selected decisions in the course of a treatment but is the general rule. Surely the patient should be informed about risks and chances of a treatment, but what does it mean to tell him the truth in this context? Informing him fully would mean to send him through encompassing medical and biostatistical studies with regard to his and related diseases and differential diagnoses. That is unrealistic and cannot be the point of telling a patient the truth and let the autonomous decision with him. Perhaps even more significant: it is not what patients expect of doctors: to be teachers in medical knowledge so that the patients are able to decide all aspects of their treatment. Even medical doctors—even specialists in the respective discipline—are strongly advised not to treat themselves or close relatives, because a reasonable balance of the risks at hand is hardly to do in an emotionally overly demanding situation: in pain, in fear for one's

[6] E.g. that all men will die, and will die without oxygen, water, food etc. Even that they will die if they fall without parachute from 3000 m height is not true without exceptions.

life or for one's nearest. It seems an inappropriate goal to put the patient in the situation of a biomedical specialist who is affected himself, and expect that he should take the whole burden of uncertainty in the pending decisions on his own.

Telling the truth in this context must mean to inform the patient about the good chances to get help from this medication, and inform him about the more probable and the more dangerous adverse effects that could happen. In the course of treatment, it is the physician's responsibility to ask actively about the more common side effects and to control laboratory results in order to minimize severe dangers. It is part of a physician's expertise and responsibility to control the uncertainty implicit in medical knowledge as good as possible. Having informed the patient is not enough.

3. Doctor-patient-communication (1) or what is "*relevant* truth"?

A second pitfall in the seemingly simple demand to inform the patient adequately is hidden in the limitation of telling only the "relevant" information. It is obvious that the patient cannot be told about all medical known facts. That is not feasible, not wished and not necessary for an autonomous decision. All details that do not influence the patient's decision and his understanding of his situation are negligible. But how should the doctor know in advance what will be important for the patient, in order to decide? Given the same medical situation, this is individually very different. Many patients, confronted with a choice between different examinations, treatments or non-treatments will prefer not to be bothered with too many details and improbable outcomes, but get a pre-selected choice, with an understandable interpretation of options that could be comparably reasonable candidates of choice. Others want much broader information, value certain aspects differently than average people, or want also to get presented alternatives that are not supported by medical evidence (e.g. new and experimental or so-called alternative therapies).

Giving the relevant information therefore implies not only having the necessary knowledge and reproducing it. It also means choosing among it with regard to the needs of the patient. In order to be able to do that, the doctor has to know the patient, his general mental structure, his values and preferences pretty well. In fact, even if she has met him many times before, she cannot know how he will react facing this special and new situation—or if he might have changed his mind in relevant ways since she met him the last time. The only (and only seemingly trivial) thing she can do is to talk with the patient, to ask him about his life, his values, his preferences, his world view, his family situation, his work and hobbies and so on. Giving relevant information requires that she has at least an idea what could be relevant for

the patient and his decision. Practically, this cannot be a unidirectional process. It has to be an interaction, and the relevancy of the available medical knowledge can only be developed in this mutual information process between doctor and patient. At first view, this might appear only as a small and nice, humane addition to the obligation to inform truthfully, such as: "be also kind, polite and communicate decently with the patient". Actually, it is an essential part of detecting the relevant information at all. The information I ought to give is unknown to me, if I am not detecting it together with the patient.

Perhaps this is what is meant by the ideal of "shared decision-making", in the deliberative model of the physician-patient relationship (Emanuel and Emanuel 1992) but it is useful to be a bit clearer and more detailed in what should be shared, or perhaps better: exchanged.[7] It is not the psychological part of decision-making which is very different for doctor and patient. Establishing a good contact is essential for just doing the basic task: detecting the relevant information and giving it to the patient in order to enable him to make his decisions. The flow of information comes from both sides, but the kind of information, the demands on both protagonists with regard to empathy and receptiveness are different. The patient is the expert on the values, settings and meanings of his own life that might be threatened by his illness—and by available therapies. The physician is the expert with regard to available medical knowledge and medical interventions. Together they have to develop those parts of knowledge that are meaningful for the patient, and those options that require decisions. In order to do this successfully, it is more trust that is required from the patient, and more empathy from the physician.[8] On the other hand, the patient needs more receptivity of technical and epistemological facts, and the doctor more didactic capacities of explaining them to someone in a difficult situation. That is, both of them need to be open for those meaningful elements of knowledge the other one is expert in, and both need to try to facilitate the exchange of them. Both have the common but difficult task to find a common language level, in order to understand each other correctly and give that part of the huge amount

[7] Actually, two of the four models imply different types of shared decision-making: the interpretive and the deliberative model. The influence as well as the responsibility of the physician is bigger in the deliberative model. In the deliberative model the doctor helps the patient not only to decide, but also to develop his values. Though this is the model favoured by Emanual and Emanual, it goes a step farther than supported in this article. I try to show how much relational interaction is already needed for the interpretative model, and in order to emphasize this, I prefer to call it a hermeneutic model. It is, however, very close to the interpretive model.

[8] For a more detailed elaboration of the role of empathy for professional medical ethics see (Gelhaus 2012).

of details to the other in a way that contributes to mutual understanding of the state of affairs. A tentative illustrative model would be a spiral-like process of developing in a dialectic hermeneutic process that thing that could be called "relevant truth".

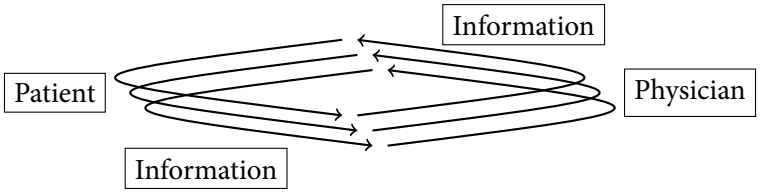

Fig. 2. *Hermeneutic Model of "Relational Truth Creation".*

It is noteworthy to stress that this is not only a more complicated way of the linear transfer of information but a process of construction instead of mere transmission.

4. Doctor-patient-communication (2) or what means "telling"?

However, there are simple cases. Some information is simply relevant for *all* people as in our above mentioned example of incurable cancer. Here such a difficult process to select the relevant aspects of medication is certainly not required. So the modern variant of the story told in the introduction could look like this:

Hurrying through his daily round, the ward physician enters a room with three patients, greeting shortly and informing the patient in the second bed: "By the way, according to the pathology results your tumour is a cancer and it is beyond curative treatment. You can leave the hospital today." After having dealt with the other two patients, informing them about their diagnostic results, she leaves the room.

This story can occur this way, but it is of course not according to the state of the art. Medical students are taught the ways of "breaking bad news", in many medical schools this is trained with role plays and with practical advices as to choose the right setting (not with other persons in the room), to have enough time for this talk, to have, in fact, repeated times to talk with the patient about it, because it is difficult to accept this message. One often emphasized aspect is to leave hope to the patient—not illusionary hope for a miracle, but for on-going support and palliation. So the vignette is not presenting the modern ideal. But within the scope of this article the interesting question is: Why is this not the ideal way of "telling the truth"? It is obvious that this truth is relevant, and this needs no empathy with the specific patient. It also seems to be a situation where no medical decisions are at hand. Later, there may come up further questions of different palliative options that require more differentiated information of the patient,

but with regard to the present state of medical knowledge the relevant aspects are obvious enough and do not require long interactions. The uttered information is indeed the relevant one, and it is given in a clear, understandable and unequivocal way, without using much medical jargon. As there are no medical means to influence this information, there are no further explanations required. However, the daily life and the future of the patient are deeply addressed, and so the patient needs this information for all kinds of autonomous non-medical choices. Why is it still wrong to tell the truth this way?

One answer is that "uttering in an understandable way" is not what is meant by "telling". "Telling" something to someone means that the sender of information is aware of the receiver. Secondly, it means that the sender is aware of different modes of transferring the information, and is choosing one of them that is best suitable to address the receiver in an intended way. If it would be the case that the intention was only to give the information to the patient, the method chosen in our example would not be wrong. Actually, that is not the point of the ethical demand to tell the truth. The point is to enable the patient to make autonomous decisions. If the doctor only fulfils the part of *giving* the information and leaves the rest to the patient she is not *telling* the truth, because she does not care about the receiver and the reception, and she does not facilitate to receive it in the right mode of understanding.

If you tell a criminal story, it is not sufficient to sketch the content. In fact, it would be wrong to do so at first hand. You have to build up tension, wrong tracks, and alternatives. You have to keep the interest of your listener awake, and you are allowed to use all kinds of means for that. Revealing the information what happens in the story and why is counter-productive—it should only get clear in the end, and it should be surprising, neither *ad hoc* nor foreseeable. (Masters of the art can play with these demands, and start with the solution, proving their mastery in keeping up the tension in spite of that). Similarly, the disclosure of medical facts to the patient is not only a matter of information to pass. The ethical goal of telling the truth to the patient implies to give the information in a way that enables the patient to take it, to work with it, and to use it in a way that is compatible with his autonomy.[9] Telling it while other people are listening does not only violate

[9] Of course these insights are not very inventive. All important authors who have worked about Informed Consent spend much effort on showing failures to avoid (as e.g. compulsion) and on the measures necessary to translate the relevant medical knowledge into a language that is understandable for the individual patient. (e.g. Faden and Beauchamp 1986, Wear 1993) What I intend to show is that a too simple idea of information the physician has to give is inconsistent, and that, on the one hand, many seemingly additional points to consider (like creating a good contact with the patient) are necessary elements

confidentiality but also demonstrates lacking respect and lacking empathy. A normal reaction to such a bad message could be shock, unbelief, anger, panic, grief and so on. Nobody would like to have strangers as witnesses of one's immediate reaction. It is an extreme example of intrusion in one's privacy. The patient is urged strongly *not* to react normally, but to pretend the message would not provoke strong fears and emotions as it would be appropriate.

Giving the information without giving the patient the opportunity to react, and without the time to see and to answer to the reaction, means that one is trying to give the information without its full meaning. It is not the "truth", i.e., the content that is given, but (however understandably formulated) as an abstract code, and the painful decipherment is left to the patient alone. "Telling" the truth would mean to help the patient to grasp also the meaning of the message, with its painful and existential impact. This would, however, imply that the doctor, though not coming into the same kind of endangered situation as the patient, would be open for painful and existential experiences, that she could understand them to a certain degree and could stand to be with persons who are exposed to them. The mode of giving painful or frightening information requires that one also addresses these dimensions.

All things considered, there are different implications in the seemingly clear and simple imperative "Tell the truth" to the patient: the epistemological and statistical status of medical knowledge and the many dimensions of meaning that the information contains for the patient. None of them can adequately be given unidirectional to the patient, but they have to be developed together in a rich, complex, and multidimensional communication. This communication, at the same time, fulfils additional necessary tasks, using and establishing a relationship between patient and doctor, informing the *doctor* about essential facts (anamnesis), justifying trust and enabling the doctor to give confidence and comfort. Hence, the borderlines of informed consent, diagnostics and therapy are open and the same communication can and ought to serve all these different goals at the same time. It is a merit of philosophy to distinguish the different aspects that have to be considered. The analysis and distinction make it easier to clarify the goals and means and their hierarchy and to point to fatal misunderstandings about what is in the patient's best interest. It is the task of prudential practice, however, "to put Humpty-Dumpty together again" (Cassell 1991) and not to work only according to a checklist of necessary elements. Signing an informed consent sheet is not necessarily expression of autonomy, and uttering medical facts,

of the very core of disclosure, while some warnings of things to avoid (like manipulation) can be exaggerated or at least have to be discussed sophisticatedly in context of a certain situation.

even in a translation to everyday language, is often no sufficient disclosure.

5. Manipulation and truth creation

If the relevant information is often not something at hand but something that has to be elaborated by doctor and patient together, how far may each of them go in shaping the truth? According to constructivism and postmodern ideas, both have their own truths, constructed by their unique life history and socialisation in their respective (or common) culture. The doctor has been socialized in medical education and has ideas on the state of the patient that are probably shaped by science and medicine, the patient has his own ideas. No perspective is superior, and there is no independent observing standpoint from which an adequacy could be judged. Is then the process of creating a common level of truth a negotiation between both truths, a mutual manipulation until equilibrium is reached? How could one prevent that one that is more eloquent convinces the other totally of his position? If one is more stubborn, and one less confident, can this influence the truth? Would it be possible that both come to the conviction that the cancer diagnosis is irrelevant and indulge in the folie-á-deux that the patient is perfectly healthy, and could that still be called truth? That does not only seem absurd from a common sense point of view. It is also an inconsistent description of the situation. Usually, the patient comes to the doctor because he has at least some conviction that the doctor can do something in order to help him, and he has some ideas about modern medicine and its scientific foundation. So both patient and doctor are on a common ground and accept the existence of a reality that can at least partly be detected and influenced by medicine.

Creating a "truth" that contradicts the facts could not be called a truth in a medical setting. Insofar a certain form of correspondence theory of truth is unavoidable if one does not deconstruct the whole situation of patient and physician. Nevertheless, it is hard to understand how one can reach a common level of truth without being flexible—on both sides—in the understanding, interpretation, and explanation of the facts. Thus, one has to give up at least temporarily one's own relation to the facts—i.e. one's truth. The facts are not influenced, the truth, as the relation of one's mind to the facts, is. If the doctor tries to find out the patient's convictions about the disease, she cannot do so if she insists on her own view on it. She should not be sceptical, ironic or show a conviction that her own view is superior and closer to the facts. If she wants to understand the patient's ideas, she has to take them seriously, even if they oppose her own ideas. This should better not be a jovial reserve of someone who knows better. The doctor is on the track of necessary information, often as important as some laboratory or x-ray results. At the same time, this information from the patient is the necessary

basis for explaining the information the doctor wants to give. Hence, for an explanation, the convictions of both protagonists in relation to given facts have to be adjusted to each other. So, in a relational process, *a common truth compatible with the known facts is constructed*.

May one then even betray one's own understanding of truth, lie, in other words, in the service of a relational truth creation? Partly, this is a question of finding a common language and understanding each other's metaphors correctly. If both of them, doctor and patient, communicate about a heart failure, e.g., this may imply different things—and it is not always the doctor who has the more mechanistic idea about a dysfunctional pump that has to be repaired. The heart is also an organ necessary for life, it is a metaphor for the most important part of a whole, it is related to love and emotions, it is addressed by so-called stress hormones and it is together with kidneys and pituitary gland involved in the complex regulation system of water, electrolytes and blood pressure. The task to talk about the same thing is not trivial, the more as one is not necessarily aware of all connotations one bears in mind (Gelhaus 2009). If the doctor tries to explain the results of different diagnostic procedures, she has to find out the pre-understanding of the patient, and she has to explain what in his organism is wrong, and the consequences of this. The mechanistic allegory of a defect pump might be useful to explain and demystify, it may be close to or very far from the patient's ideas, it might be a comfort or a disrespectful banalisation for the patient. In a therapeutic intention, the doctor might want to explain the situation in a way that motivates the patient to take his disease seriously enough to take his medication and (perhaps more difficult) change his lifestyle, take daily promenades and stop smoking. On the other hand, she does not intend to frighten the patient too much, to make him fatalistic or even depressive. The choice of words, the tune, and the importance that is laid to the information are not innocent. They bear a therapeutic and educative as well as a destructive potential, and also a potential of a missed chance, of course.

At one end of the scale there is the bare information, and one could understand the pitfalls of communication as a disturbance that has to be overcome as good as possible. At the other end there is a paternalistic conviction to know for sure what is best for the patient, and to use all means to bring him there, even if that means hiding the truth (not informing him about a conservative treatment option as an alternative to an operation, e.g.) or actually lying, i.e. making him believe something that is not the case. Both extremes seem to be wrong. Both do not take the goals of the doctor-patient-communication seriously enough. The first one overemphasizes a misunderstood idea of patient's autonomy, the other one a misunderstood idea of the doctor's role and the welfare of the patient. But between the wrong

extremes—where is the right middle? How much adjustment of the facts to suitable explanations, according to the pre-understanding of the other is needed, or legitimate? May I even tell a literal lie,[10] in order to create an understanding in the other that is appropriate to the facts? How much may I influence the other, and how much *should* I do that?

There is no easy answer to this question, but the emphasis of modern medical ethics on patient's rights and autonomy, if understood in a complex way and with consideration of the realistic situation of a patient, gives an orientation. The aim of all communication directed on disclosure is to enable the patient to understand his situation. The task of healthcare is to help the patient in his health problems, but usually not against his will.[11] Though the doctor might think she knows better what the right decision is, she must not trick the patient into this solution. She may use strong means to convince him, but the alternatives and their consequences should be clear for the patient.

The question of choosing explanations and metaphors together with the patient in order to create a common level of understanding of the relevant facts is a separate question. Here it may be legitimate and sometimes even necessary to pretend things that do not really match one's own understanding, for reasons of under-complexity or as a correction of exaggerated or clearly wrong ideas. As an extreme, a "white lie" in this regard might be acceptable.[12]

> E.g.: Patient: "Are you really sure this is the best for me?"
> Doctor: "Yes!" instead of "No, it is only a statistically founded judgment according to the current state of knowledge. I cannot know, I only hope it is the best for you."

In this example, there is a subtext hidden behind the literal question. The patient asks if the doctor has conscientiously chosen a good therapy (the best one), and at the same time he asks for reassurance, and perhaps also for comfort. If the doctor does not answer with explaining more clearly which

[10] As a "literal lie" I understand a lie where the explicit words express something that is actually wrong according to the convictions of the speaker. Thus, it is meant as the opposite to "literal truth", when all words are in congruence with the facts, though the message may be—intentionally or unintentionally—distorted. A "literal lie" is not a blank "lie" if it is not used with the intention to fool the listener, but with the intention to bring him to a more adequate understanding of the situation. Therefore, a "literal lie" can be used to create a "relational truth".

[11] Exceptions are if the patient is not able to understand his situation and/or his disease, as it occurs with some psychiatric diseases, or in early childhood.

[12] A "white lie" is a lie that is told with a socially supporting intention (e.g. politeness: "Your new dress looks wonderful", even if the speaker thinks it does not suit you).

kind of knowledge she can provide, but with a confirmation that contradicts her own knowledge, i.e. her own relation to the facts, then she answers to the needs of the patient. The intention is however not to mislead the patient, or to hide or distort the facts. The menace of the disease moves the patient and influences his understanding of the situation, and the comfort of the doctor might work against this. The intention is that the scared and help-seeking patient understands that the therapy is the best option to offer from the perspective of a scientifically educated physician without frightening him even more. Choosing the second suggested answer might be literally more adequate, but lead the patient farther away from the facts. Disappointed about lacking emotional support, he might look for help from an alternative healer who offers more safety and more skill in creating a common level of understanding, but less tested explanations and less closeness to the available facts. The art of giving a good disclosure is to find out how to explain the facts to the patient in a way that enables him to make his decisions, in a state of sufficient understanding of the facts. The ideal is to find/create a common explanation that both doctor and patient could full-heartedly accept. Though it could open the door for wrong, paternalistic manipulation, sometimes even literal lies may be unavoidable on this way.[13]

6. Conclusion: Between a correspondence and a constructivist theory of truth

The intention of this article is to highlight some aspects that question a simplistic idea of truth as corresponding to the facts that is often implied in the imperative "Tell the truth!" Telling the truth is a delicate and complicated process, the more if it is embedded in other communicational tasks like therapy and diagnosis. It requires a successive development of mutual understanding, and it has educative and insofar also possibly manipulative aspects. Thus it requires hermeneutic as well as constructive capacities from both, sender and receiver of the information. Barely telling the literal truth can even be counterproductive in this process of creating an adequate understanding of the situation. Nevertheless, the truth to be reached is not a mere matter of mutual construction irrespective of facts. There *is* a real situation that has to be understood. Telling the truth means making possible a level of understanding that corresponds to this situation. This implies both, a relational construction of explanations, as well as correspondence to facts.

[13] Persons with autism-spectrum are known to have big problems with these kinds of white lies, probably because they have difficulties to put themselves empathically in the shoes of others and understand their emotional subtexts. Often, their comments are misunderstood as rudeness, instead of literal honesty (Jaarsma et al. 2012). A too 'honest' doctor runs the same risk.

Neither of it is sufficient alone.

I am emphasizing this point because of practical importance: If understood so cleanly and simple, a linear informational idea of truth either can lead physicians to disregarding the outspoken ethical demand of truth-telling (valuing the patient's wellbeing higher than his autonomy) or to obeying the rule but not its meaning (literal truth-telling, even if that means ignoring the wellbeing and the more complexly understood autonomy). If we want to be precise with our rules and their practical relevance, we need the idea of a relational creation of truth which requires activity, attention and empathy from both physician and patient. It serves the aim of truth-telling, though it may include some amount of mutual manipulation and even sometimes the pretension of things that may contradict one's own conviction of truth (literal lies). This is a dangerous method and should be used with caution and reluctance, and not with the intention to trick the patient into a situation or to make the life of the physician easier: its only justification is to enable the patient to make autonomous decisions, not to override them.

To be absolutely clear: by questioning the literal simplicity of truth-telling I do not question the right of the patient to have the last word in the pending decisions—it is his life, and his values should be decisive. We ought not to dismiss or to go below a standard of "Informed consent". But having this ideal of medical ethics in mind, we have to realize the basically interactive nature of this delicate mixture of contents that has to be transmitted. The demands on a physician are definitely different from those on a salesman who informs about his offered products, and also from those on a science teacher or on a science reporter. They require an equally active and manipulative part in the interaction, but the goals and the adequate means are different. The goals of the physician-patient-communication are the goals of medicine: the well-being of the patient. Medical ethics has rightly emphasized the dangers of paternalism, and reminded the medical profession forcefully that since Enlightenment it is hard to see how well-being could be understood without respect for a person's autonomy. It would be fatal, however, to understand this warning as a sign to leave the traditional goals of medicine behind, to focus on a literal understanding of medical information, and rely for practical regards on a rationalistic, informational ideal of the patient's autonomy alone.

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